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No. 83-727

IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

LAMAR ALEXANDER, Governor of the State of Tennessee, Et Al.,
Petitioners,

vs.

HERSHEL CHOATE, Et Al.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

REPLY BRIEF OF THE PETITIONERS, LAMAR ALEXANDER, GOVERNOR OF THE STATE OF TENNESSEE, ET AL.

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REPLY BRIEF OF THE PETITIONERS, LAMAR ALEXANDER, GOVERNOR OF THE STATE OF TENNESSEE, ET AL.

This case involves the legality of a decision by the Tennessee Medicaid Program to reduce the number of inpatient hospital days the Program provides in a fiscal year to each eligible recipient from 20 to 14. At issue is whether or not this reduction violates § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (hereinafter § 504), and regulations promulgated thereunder. The District Court found no violation of § 504 in that both the handicapped and nonhandicapped were extended the same number of inpatient hospital days. The Court of Appeals, however, reversed the District Court and found a *prima facie* violation of § 504 because, at the 14-day limit, a greater percentage of the nonhandicapped than the handicapped would have all their hospital needs satisfied.

Two issues are presented to the Court in this appeal. First, does § 504 prohibit "intentional" discrimination only or does it also prohibit unintentional activities with a discriminatory "effect". Second, if discriminatory effects are prohibited, did the Court of Appeals properly apply the standard in finding a *prima facie* violation of § 504.

I. THE THRESHOLD ISSUE IN THIS CASE, WHETHER § 504 PROHIBITS DISCRIMINATORY EFFECTS, HAS *NOT* BEEN CONCEDED BY THE PETITIONERS AND IS PROPERLY BEFORE THE COURT.

The Respondents contend that in the District Court and the Court of Appeals, the Petitioners "conceded that § 504 applied to practices with a discriminatory effect. . .." (Respondents' Brief, pp. 2, 3). A review of the record reveals no such concession and otherwise supports the propriety of the Court addressing the important and fundamental questions raised by the Petitioners regarding the nature of the discrimination prohibited by § 504.

In the District Court, the Petitioners' position was clearly articulated. It contained no concession as to the application of an effects standard. The Petitioners simply argued that as long as the Tennessee Medicaid Program extended the same number of inpatient hospital days to the handicapped as to the nonhandicapped, it was not in violation of § 504.[1] The District Court

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[1] The Pre-Trial Order in the District Court contained a summary of the Petitioners' defense to the allegation that § 504 had been violated. It provided:

> If Plaintiffs' interpretation of federal laws and regulations regarding discrimination of handicapped individuals, as applied to the proposed reductions, is carried to its logical conclusion then the only limit the program will be allowed to place on services would be at a level providing all of the medical needs of the handicapped. As long as the Tennessee Medicaid Program makes available to handicapped individuals, the same services it

agreed and ruled in the Petitioners' favor. Though the District Court's opinion stated that a disparate impacts test was an appropriate standard under § 504, it declined to apply the test as being unnecessary to decide the case. The District Court ruled that the alleged disparity between the handicapped and nonhandicapped did not amount to discrimination under § 504.

In the Court of Appeals, the Petitioners reiterated the position established in the District Court.[2] Likewise, the Petitioners made no concession that § 504 prohibited discriminatory effects.[3] The Court of Appeals rejected Petitioners argument and reversed the District Court. It based its decision on the failure of the trial court to make a proper inquiry into the "discriminatory effects" of the 14-day limitation. The Court

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> makes available to nonhandicapped individuals, it is in compliance with all federal laws and regulations regarding discrimination against the handicapped. The Tennessee Medicaid Program fully complies with this requirement. (Pre-Trial Order, Theory of the Defendants, p. 3).

The post-trial Proposed Findings of Facts and Conclusions of Law of the Petitioners urged the Court in similar language to find that no violation of § 504 existed. (Proposed Findings of Facts and Conclusions of Law, p. 7, ¶ 13.

[2]Brief of Appellees, pp. 9-14.

[3]The Respondents point to only one portion of the record in support of their assertion that the Petitioners "conceded" this issue. At page 12 of the Brief of the Appellees in the Court of Appeals, the following appears:

> The statistics and studies were computed and analyzed by the parties in several different ways during the course of the trial. Suffice it to say, the studies indicated that the handicapped population of Medicaid recipients would suffer proportionally more from the reduction in hospital benefits than the nonhandicapped Medicaid recipients.

From this language, which does nothing more than summarize various studies, the Respondents glean a major concession on a broad egal question.

then applied its own disparate impact analysis and found a *prima facie* violation of § 504. This was the first time in the progression of the case that a discriminatory effects standard and its related disparate impacts analysis became at issue. The Petitioners, therefore, properly seek review in this Court of the Court of Appeals' use of a discriminatory effects standard to determine a violation of § 504.

II. THE RESPONDENTS' RELIANCE ON THE ADMINISTRATIVE INTERPRETATION AND SUBSEQUENT LEGISLATIVE HISTORY OF § 504 AS EVIDENCE OF CONGRESSIONAL INTENT TO PROHIBIT DISCRIMINATORY EFFECTS IS MISPLACED.

The Respondents' cite as evidence of Congressional intent to prohibit "discriminatory effects", the regulations promulgated in 1976 by the Secretary of Health, Education and Welfare implementing § 504. (Respondents' Brief, pp. 35-37). This Court, however, has been reluctant to give "deference" to these regulations in interpreting § 504.[4] *Southeastern Community College v. Davis,* 442 U.S. 407, 412 n. 11 (1979). Likewise, Congressional activity subsequent to the enactment of § 504, relied upon by the Respondents, is of little help in this case. (Respondents' Brief, pp. 41-46). It simply does not address the issues now before the Court.

The Petitioners have also reviewed Respondents' numerous references to the legislative history surrounding the enactment of § 504. (Respondents' Brief, pp. 15-35). The Petitioners adhere to the position taken in their initial brief that this legislative history is silent as to the precise nature of the discrimination prohibited by § 504. (Petitioners' Brief, p. 15 n. 18).

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[4]The Respondents should not confuse the regulations under consideration in this case with the regulations the Court relied upon in *Consolidated Rail Corp. v. Darrone,* No. 82-862, February 28, 1984, to answer an unrelated question of congressional intent under § 504.

III. THE ISSUES PRESENTED IN THIS APPEAL ARE UNAFFECTED BY CHANGES IN THE TENNESSEE MEDICAID PROGRAM SUBSEQUENT TO TRIAL IN THE DISTRICT COURT AND DO NOT WARRANT A REMAND AS SUGGESTED BY THE RESPONDENTS.

The Respondents contend that two changes in the Tennessee Medicaid Program, subsequent to trial in the District Court, "may" have "aggravated, mitigated, eliminated, or altered" the "adverse impact" upon the handicapped. (Respondents' Brief, p. 63). The Respondents suggest that the case be remanded to the District Court for further evidentiary proceedings. The suggested remand is unwarranted for several distinct and compelling reasons.

First, the changes in the Tennessee Medicaid Program cited by the Respondents have had a de minimus impact upon program recipients and services. For instance, the first change simply restores the former 20-day inpatient hospital level to a very limited group of persons under 21 years of age.[5] These are individuals who receive special diagnostic screening through the Early and Periodic Screening, Diagnosis and Treatment

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[5]A copy of the Tennessee Medicaid Program regulation describing this change is set forth in the Appendix to this Brief at A-1. A somewhat different description of this change is set forth in the Solicitor General's Brief, pp. 5a-9a, in a Notice of Approvai from the Secretary of Health and Human Services. It is apparent that subsequent to the Secretary's approval, the Tennessee Medicaid Program actually implemented the change in a broader scope than originally planned.

(EPSD&T) component of the Medicaid Program.[6] This change impacts only a handful of recipients.[7]

Likewise, the second change cited by the Respondents had only a minimal effect on the Program. The Respondents are greatly mistaken in their assessment of this change. They claim that it "exclude[d] entirely from [the] program a substantial number of individuals who were covered by Medicaid in 1980". (Respondent' Brief, p. 62). Quite to the contrary, this change in 1982 merely "reclassified", not "eliminated", most of one broad group of Medicaid eligibles (medically needy) into another broad classification (categorically needy). In this reclassification process, there was only a small subcategory of individuals who lost eligibility for benefits.[8]

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[6]As a condition of receiving federal financial participation, a state Medicaid Program must provide Early and Periodic Screening, Diagnosis, and Treatment (EPSD&T) to eligible recipients under 21 years of age. 42 U.S.C. § 1396a(a)(4) and 42 C.F.R. § 441.50 *et seq.* Unlike other Medicaid services which are utilized to alleviate a perceived illness or other malady, EPSD&T is aimed at early diagnosis and treatment of conditions in apparently healthy children and youth. The Program also includes dental screening. EPSD&T screening is available to all Medicaid recipients under 21 and they are encouraged to participate. 42 C.F.R. § 441.75.

[7]Though precise figures on the number of individuals under 21 who would be affected by this change are unavailable, it would appear to be modest. According to reports filed by the Tennessee Medicaid Program with the Secretary of Health and Human Services, Tennessee screened 4,960 individuals during the month of June, 1984. *See* Appendix to this Brief, A-2. These screenings resulted in detection of 2,086 medical problems, of which 1,223 were dental related. Of the remaining 863, the increase in hospital days would affect *only those individuals whose condition required hospitalization, if at all, in excess of 14 days.*

[8]Though the change did, in fact, eliminate most "categories" of eligibility under the broad heading of the "medically needy" category, it eliminated very few of the "recipients" who made up the category.

More important than the de minimus nature of these changes is their irrelevance to the issues in this case. No doubt these changes may slightly alter the statistical data relied upon by the Courts below. Accordingly, the precise numerical ratio of handicapped to nonhandicapped who will have all of their inpatient needs met at the 14-day level may be slightly different today than calculated by the District Court in 1981. The issue before this Court, however, is not the "current" accuracy of this statistical ratio. The issue is whether that ratio and the analytical process which produced it is at all relevant to an inquiry under § 504. Specifically, does § 504 prohibit discriminatory effects and, if so, did the Court of Appeals apply a proper standard to ascertain such effects? A remand to the District Court will in no way aid this Court in resolving these issues. It may, however, be seen as a tacit approval of the standard adopted by the Court of Appeals.

Finally, a remand to the District Court could prevent the unsettled issues in this case from ever reaching this Court. Since the Tennessee Medicaid Program is not a static entity, but a large, complex and continually changing social welfare program, it will always be subject to the types of changes the Respondents argue requires a remand. If the Respondents have their way, the Tennessee Medicaid Program will have to be frozen at some specific point in time to preserve the ripeness of the important issues now before the Court.

Virtually all of them were shifted into newly-created classifications under the other large classification of "categorically needy". A Tennessee Department of Human Services' Bulletin describing the change is attached hereto as Appendix A-3. As noted in the very first paragraph, the only individuals whose "*eligibility will be eliminated have been eligible for only restricted services through the Medicaid Program since July 1, 1981.*" (Emphasis supplied). These persons were not counted in the statistical data used by the District Court in 1981. The Bulletin also contains good examples of the "reclassification" of individuals whose category was eliminated. *See, e.g.*, ¶ A.1. of the Bulletin.

CONCLUSION

For the reasons set forth above, and in their initial Brief, the Petitioners respectfully request that the decision of the Sixth Circuit Court of Appeals be reversed.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing Reply Brief of the Petitioners, Lamar Alexander, Governor of the State of Tennessee, et al., has been forwarded to the below-listed counsel, on this the 21st day of September, 1984.

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APPENDIX

APPENDIX

RULES OF

Tennessee Department of Health And Environment

Division of Medicaid

GENERAL RULES

CHAPTER 1200-13-1

Rule 1200-13-1-.03 (AMOUNT, DURATION AND SCOPE OF ASSISTANCE) (1)(e) is amended by adding a sentence to this subpart. The amended rule shall read as follows:

(e) Early periodic screening and diagnosis of individuals under 21 years of age and treatment of conditions found will be covered for eligible recipients. Those individuals receiving EPSDT services shall be allowed up to twenty days of inpatient hospital services and twenty physician inpatient hospital visits per fiscal year.

Statutory Authority: T.C.A. 14-23-105, and T.C.A. 14-23-109

Rule 1200-13-1-.03 (AMOUNT, DURATION AND SCOPE OF ASSISTANCE) (1)(a) is amended by adding the words, "except as set out in Rule 1200-13-1-.03(1)(e)" at the end of the first sentence so that the rule reads as follows:

(a) In-Patient hospital services other than those provided in an institution for mental disease or tuberculosis will be limited to fourteen days per fiscal year, except as set out in Rule 1200-13-1-.03(1)(e). Any hospital days paid by insurance or other third party benefits will be considered to be days paid by the Medicaid program. Friday and Saturday admissions will be limited to emergencies or surgery the same or next day.

Statutory Authority: T.C.A. 14-23-105, and T.C.A. 14-23-109

FORM SRS-NCSS-120

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social and Rehabilitation Service
National Center for Social Statistics

OMB No. 83-R0295 -
Approval expires 7/31/75

MONTHLY STATISTICAL REPORT ON MEDICAL CARE
PART III
Number of Individuals Receiving Early and Periodic Screening Services and Payments for such Services

State Tennessee Report for month of June, 1984

Item	Age of children screened		
	Total (1)	Under age 6 (2)	Age 6-20 (3)
1. Number of individuals screened during month *(sum of 2 and 3)*	4,964	3,683	1,281
2. Number with no referrable conditions uncovered or suspected during screening	1,679	803	876
3. Number with referrable conditions uncovered or suspected during screening *(sum of 3a and 3b)*	3,285	2,880	405
a. Referred during month for diagnosis and/or treatment	2,996	2,671	325
b. Not referred	289	209	80
4. Number of individuals screened with:			
a. Visual problems	374	93	281
b. Hearing problems	122	82	40
c. Dental problems	1,223	512	711
d. Lead poisoning	4	2	2
e. Other problems	363	226	137
5. Total payments for screening services	$ 158,868	$ 114,559	$ 44,309

— A-2 —

BEST AVAILABLE COPY

STATE OF TENNESSEE
DEPARTMENT OF HUMAN SERVICES
NASHVILLE

MAY 17, 1982

BULLETIN NO. 65
MN-82-13
FA-82-29
SS-82-19

To: Regional, County, and Area Offices

From: Sammie Lynn Puett, Commissioner

Subject: Medicaid Eligibility Changes

Effective July 1, 1982, the Department of Human Services, in cooperation with the Department of Public Health, intends to implement cost containment measures in the Medicaid program which will eliminate eligibility for certain persons classified as Medically Needy. Individuals whose eligibility will be eliminated have been eligible for only restricted services through the Medicaid program since July 1, 1981. As of July 1, 1982, all individuals determined eligible for Medicaid on or after July 1, 1982, will receive a non-restricted Medicaid card which will provide them with the full range of Medicaid services provided in Tennessee.

As of July 1, 1982, several coverage groups and categories of eligibility will be added. This bulletin is being issued to alert staff to the proposed changes and allow supervisors to begin to plan for the desk reviews that will be required prior to implementation. Specific instructions regarding desk reviews will be issued by June 1.

A. *Ineligible Coverage Groups*

The proposed changes include termination of Medicaid coverage for the following groups of individuals under the Medically Needy program:

1. **Medically Needy Aged, Blind, and Disabled**

   Non-institutionalized aged, blind, and disabled individuals will no longer qualify for Medicaid in Tennessee unless they are eligible for SSI. Arrangements are being made to cover any aged, blind, or disabled individuals that are institutionalized in long-term care facilities as categorically needy under a special eligibility category.

2. **Caretaker Relatives and Second Parents of AFDC-MN Children**

   Parents and caretaker relatives of AFDC-MN children will no longer be eligible for Medicaid coverage in their own right unless they qualify for AFDC or SSI or are pregnant (see B-2-a). AFDC-MN children will continue to be covered.

3. **Eligible Coverage Groups**

   1. **Categorically Needy**

      The current Categorically Needy coverage groups will be retained. In addition, the following new coverage groups will be added to this category:

      a. Individuals in long-term care with income less than 300% of the SSI Federal Benefit Rate for an individual living in his/her own home.

      b. Individuals in long-term care who would be eligible for AFDC or SSI except for their institutional status.

      c. Children 18 to 21 with special diagnoses. (These diagnoses are yet to be defined in their entirety.)

      d. Children under 21 who are deprived of parental support and would qualify for AFDC except for age.

e. Unborn children who meet the financial requirements for AFDC and would eligible for AFDC *if* born and *if* deprived of parental support. This includes coverage of unborn children in intact families in which deprivation of parental support is not a factor. Prenatal care will be available to unborn children who are needy by AFDC standards but are not deprived.

2. **Medically Needy**

Under the Medically Needy program, the full range of services will be provided to the following new groups:

a. AFDC-MN children *only,* including unborns, as the adult caretaker is no longer eligible *except* for the pregnant woman who, but for income and resources, would be eligible as Categorically Needy and who meet the Medically Needy financial requirements.

b. Children with special diagnoses.

The Medically Needy program will continue to extend benefits to other eligible groups of children under 21 as it has heretofore. These include children in foster care, subsidized adoption, psychiatric hospitals and other special living arrangements.

While it is anticipated that the above changes will not be effective until July 1, certain modifications to the eligibility process must be implemented now to ensure an orderly transition. It is important that the eligibility period on Medicaid approvals processed under the spend-down provision *NOT* extend beyond June 30, 1982. This will result in some eligibles receiving coverage for only one or two months depending on application date. As new applications are processed, applicants should be advised of the time limitation.

It will be necessary for county offices to continue accepting applications through September, 1982, on Medically Needy adults requesting retroactive Medicaid coverage. Eligibility on such applications can be determined only through June, 1982.

It is also anticipated that all non-institutionalized adult Medically Needy cases currently active for Medicaid will be closed effective July 1, 1982, with the recipients being given 10 days advance notice of adverse action.

All parents and caretaker relatives currently in AFDC-MN cases will be removed effective July 1, 1982, except for those parents who are known to be pregnant at the time of the anticipated removal. AFDC-MN income and resource policies are presently being re-written tro match AFDC policy, and all AFDC-MN exceptionally eligible cases must be reviewed in June in light of those new requirements. Further details on the processing of these actions are forthcoming.

A desk review will also be necessary to convert the institutionalized Medically Needy cases to the special categorical eligibility category by July 1, 1982. It is anticipated that Systems can provide assistance with that desk review and that it will be done in conjunction with the annual SSA desk review.

Please direct any questions regarding these anticipated changes to the Medical Assistance Policy Unit.

SLP:AMW:rw